

**THIS DECISION HAS BEEN APPEALED. THE  
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

**SOAH DOCKET NO. 453-04-8086.M5**

MDR Tracking Number: M5-04-2082-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 3-10-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the office visits, aquatic therapy, massage therapy, and special reports from 12/12/03 through 1/07/04 were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service 12/12/03 through 1/07/04 are denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 23<sup>rd</sup> day of June 2004.

Regina L. Cleave  
Medical Dispute Resolution Officer  
Medical Review Division

RLC/rlc

May 11, 2004  
MDR Tracking Number: M5-04-2082-01

IRO Certificate # 5259

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by \_\_\_\_ or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

### See Attached Physician Determination

\_\_\_ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or

providers or any of the physicians or providers who reviewed the case for determination prior to referral to \_\_\_.

### CLINICAL HISTORY

Available information suggests that this patient reports experiencing bilateral knee injury that occurred while at work on \_\_\_. The patient appears to have been seen initially by \_\_\_, on 11/12/99 for bilateral knee pain, shoulder pain and low back pain. The patient was seen for orthopedic evaluation with a \_\_\_, and eventually had arthroscopic surgery to her right knee. Recommendations appear to be made for left knee surgery as well but no specific report of this is provided for review. The patient is also diagnosed with significant degenerative lumbar disc disease superimposed post-laminectomy syndrome of 30 years previous. The patient undergoes pain management with a \_\_\_ and begins treatment with \_\_\_ and \_\_\_ in the summer of 2001. Chiropractic reports from \_\_\_ suggest that the patient continues to complain of anxiety, depression and frustration with continued pain and return to work activity. As of October 2001 the patient continues with chiropractic therapy and multiple modalities for neck pain, headaches upper back pain, low back pain and bilateral knee pain. The patient is said to have experienced a subsequent injury on \_\_\_ involving her right knee and lower back but no specific reports of this are provided for review. The patient is apparently seen again by \_\_\_ on 12/12/03 for exacerbation of neck, left shoulder and left knee conditions due to cold weather. The patient apparently denied any interim accidents or illnesses, and no mention is made of second injury of \_\_\_ in chiropractic reports. The patient is apparently given 6 visits of therapy for re-exacerbation of 08/17/99 neck, shoulder and knee conditions only. No specific doctor's notes or progress notes of these therapy sessions are provided for review.

### REQUESTED SERVICE (S)

Determine medical necessity for office visits (99124, 99213), aquatic therapy (97113), special reports (99080) and massage therapy (97124) for period in dispute 12/12/03 through 1/7/04.

### DECISION

Denied. Medical necessity for these ongoing treatments and services (12/12/03 through 1/7/04) **are not supported** by available documentation

### RATIONALE/BASIS FOR DECISION

Ongoing therapeutic modalities of this nature suggest little potential for further restoration of function or resolution of symptoms at four years post injury. With available documentation suggesting pre-existing degenerative conditions, interim injuries and significant behavioral or psychosocial conditions, it would appear that these issues would need to be appropriately addressed before beginning a new course of treatment for reimbursable conditions of 08/17/99.

1. Philadelphia Panel Evidence-Based Clinical Practice Guidelines on Selected Rehabilitation Physical Therapy, Volume 81, Number 10, October 2001.
2. Hurwitz EL, et al. The effectiveness of physical modalities among patients with low back pain randomized to chiropractic care: Findings from the UCLA Low Back Pain Study. J Manipulative Physiol Ther 2002; 25(1):10-20.
3. Bigos S., et. al., AHCPR, Clinical Practice Guideline, Publication No. 95-0643, Public Health Service, December 1994.
4. Harris GR, Susman JL: "Managing musculoskeletal complaints with rehabilitation therapy" Journal of Family Practice, Dec 2002.
5. Morton JE. Manipulation in the treatment of acute low back pain J Man Manip Ther 1999; 7(4):182-189.
6. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Mercy Center Consensus Conference, Aspen Publishers, 1993.
7. Philadelphia Panel Evidence-Based Clinical Practice Guidelines on Selected Rehabilitation Physical Therapy, Volume 81, Number 10, October 2001.

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review. This review and its findings are based solely on submitted materials.

No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned individual. These opinions rendered do not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.